IN THE

Supreme Court of the United States

October Term, 1976

No. 76-993

RONALD F. RIVIERE, D.D.S., INC.,
949 East Livingston Avenue,
Columbus, Ohio 43205,

Petitioner,

vs.

STATE OF OHIO,
OHIO DEPARTMENT OF PUBLIC WELFARE,
State Office Tower,
Columbus, Ohio 43215,
and
THOMAS FERGUSON,
AUDITOR OF THE STATE OF OHIO,
State House,
Columbus, Ohio 43215,

Respondents.

PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF OHIO

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MIDWEST LAW PRINTERS AND PUBLISHERS, INC., Columbus, Ohio 43216

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To the Honorable Chief Justice and Associate Justices of the Supreme Court of the United States:

Ronald F. Riviere, D.D.S., Inc., the petitioner herein, prays that a writ of certiorari issue to review the judgment of the Supreme Court of Ohio entered in the above-entitled case on October 14, 1976.

Respectfully submitted,

RICHARD S. DONAHEY
Attorney for Petitioner

OPINIONS BELOW

The entry of the Supreme Court of Ohio overruling petitioner's motion to certify is printed in the Appendix hereto, at page 16. The opinion of the Court of Appeals of Franklin County, Ohio, is printed in the Appendix hereto, at page 17. The Journal Entry of Judgment of the Court of Common Pleas of Franklin County, Ohio, is printed in the Appendix to this Petition, at page 29.

JURISDICTION

The judgment of the Supreme Court of Ohio was entered on October 14, 1976. The jurisdiction of this Court is invoked pursuant to 28 USC §1257(3).

QUESTION PRESENTED

Pursuant to pertinent federal statutes and regulations, a provider of dental services under contract with the Ohio Department of Welfare shall make a reasonable charge for its services. In order to determine what constitutes a reasonable charge, the Department of Public Welfare shall consider two criteria:

(1) The customary charges for similar services generally made by the provider furnishing such services; and
(2) The prevailing charges in the locality for similar services.

In determining customary charges the Ohio Department of Public Welfare uses as a basis the amount which the provider charges to non-welfare patients for a specific dental service. The question thus presented is: In determining customary charges should the Ohio Department of Public Welfare use as a basis the amount which the provider charges to only non-welfare

patients for a specific dental service or the amount the provider charges in the majority of all its cases for a specific dental procedure or service?

STATUTES INVOLVED

This case involves 42 USC §1395, 20 CFR §§405.502, 405.503, and 45 CFR §250.30. These statutory materials are printed in the Appendix to this Petition, pages 46 through 65.

STATEMENT OF THE CASE

Ronald F. Riviere, D.D.S., Inc., Petitioner, brought suit against the State of Ohio, the Ohio Department of Public Welfare and the Auditor of the State of Ohio, in the Court of Common Pleas of Franklin County, alleging that it had provided dental services to recipients of public assistance programs of the State of Ohio and administered through the Ohio Department of Public Welfare and that these Defendants had refused to pay all the amounts due for those dental services.

Plaintiff prayed for an injunction to restrain the Defendants from withholding future payments and alleged that some Seventy Thousand Dollars ($70,000.00) was then due and owing to the Plaintiff.

The Defendants counterclaimed alleging that the Plaintiff corporation owed the State of Ohio, Two Hundred, Seventy Seven Thousand, Four Hundred Twenty Three Dollars ($277,423.00) in over payments.

An action for a writ of prohibition was brought by the Defendants in the Court of Appeals for Franklin County against Judge Fred Shoemaker of the Court of Common Pleas of Franklin County praying that Judge Shoemaker be prohibited from hearing and determin-

ing the issues of the original suit. On May 28, 1975, the Court of Appeals decided that the Court of Common Pleas could proceed with that portion of the action seeking injunctive relief against the Defendants as well as the counterclaim brought by the Defendants.

In the Trial Court, an injunction was granted restraining the State of Ohio from withholding further payments to the Plaintiff. The Defendants complied with this Court order and paid the Petitioner.

The decision of the Court of Appeals was appealed to the Supreme Court of Ohio and questions presented therein were held moot.

On June 2, 1975, the Defendants began presenting evidence with respect to their counterclaim. These issues were tried before a referee of the Franklin County Court of Common Pleas and the findings of the Referee were adopted in their entirety without amendment or correction by the Trial Judge, Judge Fred Shoemaker.

That decision was in favor of the Plaintiff. It was that decision that was appealed to the Court of Appeals for Franklin County, on three assignments of error. On June 17, 1976, Judge McCormick of the Court of Appeals for Franklin County, ruled in favor of the Plaintiff on two assignments of error and reversed the Trial Court on one assignment of error and remanded the case to the Trial Court for further proceedings.

On July 13, 1976, the decision of the Court of Appeals for Franklin County was appealed to the Supreme Court of Ohio by the Petitioner on the single assignment of error that had been reversed in the Court of Appeals. In an entry dated October 14, 1976, the Supreme Court of Ohio overruled Petitioner's motion to certify and thus declined to hear the appeal.

On December 20, 1976, a notice of appeal to this Honorable Court was filed with the Supreme Court of Ohio.

REASONS FOR GRANTING THE WRIT

The Petitioner in this action is a professional corporation organized under and by virtue of the laws of the State of Ohio and known as Ronald F. Riviere, D.D.S., Inc. The offices of the corporation are located at 949 East Livingston Avenue, Columbus, Ohio.

The Petitioner employes between fifteen and twenty persons. (Tr. 27) The Petitioner has employed as many as six dentists at one time and maintains some forty thousand patient files. (Tr. 28) The Petitioner typically treats a hundred or more patients per day. (Tr. 29).

Depending on the year considered, as many as 95% (always greater than 50%) of these patients had their dental services paid for by a third party such as the Ohio State Department of Welfare, Franklin County Department of Welfare, or insurance companies (Tr. 34). Of this number, 99% were paid for by the Ohio Department of Public Welfare. (Tr. 52) The patients comprising the remainder either paid cash or Master Charge or BankAmericard which were deposited and credited by the Petitioner's bank the same as cash. The Petitioner maintained two fee schedules. Those whose services were *paid for by a third party*, were charged a *deferred fee*. Those who *paid cash* (or Master Charge or BankAmericard), were charged an *immediate fee*. (Tr. 32-33A-33).

Fees paid by the Department of Welfare to the Petitioner were accepted as full payment by the Petitioner even though they were less than the deferred fee. (Tr. 33). Because a majority (between 50% and 95%) of

the Petitioner's patients had their services paid for by a third party, a majority of all fees charged by Petitioner were fees taken from the deferred fee schedule.

The Provider Agreement or contract between the Ohio Department of Public Welfare and the Petitioner provides that payments shall be made in accordance with 42 U.S. Code 1395 and the applicable Federal regulations. It is at this point that the dispute between the Petitioner and the Defendant erupts. The Petitioner contends that his customary charge is that charge made to a majority of its patients. Since the *majority* of its services to its patients are paid by a third party, the charges are derived from the *deferred fee schedule.* The Ohio Department of Welfare contends that the customary charge is that which is charged to the *minority* of its patients who pay cash. They contend that, therefore, the customary fee should come from the *immediate fee schedule.*

Basically, the dispute between the parties boils down to the interpretation of 42 U.S.C. §1395 and the Federal regulations promulgated thereunder. The Petitioner's claim to adequate compensation for services it rendered pursuant to the contract with the Department of Public Welfare will be validated under one construction of the federal statute in question and defeated under an alternative construction. Thus the issue before this Honorable Court is clearly a federal question as that phrase has been traditionally defined by the federal judiciary. Furthermore, this federal question has been timely raised in the state courts below, having been first introduced in the trial court by means of a Post-Trial Brief.

Petitioner submits that the federal question it seeks to raise is a substantial one. The amount in contro-

versy in the instant cause exceeds Three Hundred and Forty Thousand ($340,000.00) Dollars. Needless to say, the final disposition of this controversy will have a significant impact upon the financial status of the parties.

Further, Petitioner contends that the Court's resolution of this question will have significant implications that far transcend the interests of the immediate parties to this action. In a social and legal environment wherein the federal government is daily assuming a greater responsibility for the health care of its citizens, the proper interpretation of the statutes and regulations promulgated to effectuate that responsibility becomes a matter of vital importance. Contemporay federal health care programs involve millions of dollars and effect providers who number in the thousands and patients whose number is legion. Such a matter ought not be left solely in the hands of the judicial systems of the several states. Questions so intimately bound up with an expanding national policy merit consideration by this Court. The importance of a unified coherent pronouncement on these issues, applicable to the nation as a whole, cannot be overstated.

Yet, at the present time, no such pronouncement is available. Petitioner has not located any federal cases that address the critical issues involved in the instant cause. Thus in the federal judiciary the present case is essentially one of first impression.

A brief examination of the status of the present case is indicative of the pressing need for federal review. The Supreme Court of Ohio, by overruling Petitioner's motion to certify, effectively declined to review the findings of the Franklin County Court of Appeals. As noted earlier, the Petitioner received a favorable deci-

sion in the trial court and this decision was reversed in the appeals court. Thus only two courts have given the instant question plenary consideration and these two courts reached opposite conclusions. Furthermore, notwithstanding the national scale of the issues involved, the highest court to have given full consideration to this case is a county court of appeals. The decision of that court has no binding effect beyond the borders of Franklin County, Ohio, and the matter consequently remains essentially unresolved.

CONCLUSION

Petitioner submits that the time is ripe for a plenary review of the issues involved in the present case. For the foregoing reasons Petitioner respectfully prays that a writ of certiorari be granted.

Respectfully submitted,

RICHARD S. DONAHEY
Attorney for Petitioner
TWYFORD & DONAHEY
501 South High Street
Columbus, Ohio 43215
(614)224-8166

CERTIFICATE OF SERVICE

This is to certify that a true and exact copy of the foregoing Petition for a Writ of Certiorari was served upon William J. Brown, Attorney General of Ohio, at his address, State Office Tower, Room 1625, 30 East Broad Street, Columbus, Ohio 43215, by regular U.S. mail, on this 11th day of January, 1976.

RICHARD S. DONAHEY
Attorney for Petitioner
501 South High Street
Columbus, Ohio 43215
(614)224-8166

APPENDIX

IN THE

SUPREME COURT OF THE STATE OF OHIO

Case No. 76-903

RONALD F. RIVIERE, D.D.S., INC.,
949 East Livingston Avenue,
Columbus, Ohio 43205,
Plaintiff-Appellant,

vs.

STATE OF OHIO,

and

OHIO DEPARTMENT OF PUBLIC WELFARE,
State Office Tower,
Columbus, Ohio 43215,

and

THOMAS FERGUSON,
AUDITOR OF STATE OF OHIO,
State House,
Columbus, Ohio 43215,
Defendants-Appellees.

NOTICE OF APPEAL TO THE SUPREME COURT OF THE UNITED STATES FROM THE SUPREME COURT OF THE STATE OF OHIO

Now comes Appellant, Ronald F. Riviere, D.D.S., Inc., and gives notice of appeal to the Supreme Court of the United States from the judgment entered in the Supreme Court of Ohio on the 14th day of October, 1976.

/s/ RICHARD S. DONAHEY
Attorney for Appellant
501 South High Street
Columbus, Ohio 43215
(614)224-8166

CERTIFICATE OF SERVICE

I hereby certify that a true and exact copy of the foregoing Notice of Appeal was mailed on this 20th day of December, 1976, to Robert H. Stromberg, Assistant Attorney General, State Office Tower, Suite 1625, 30 East Broad Street, Columbus, Ohio 43215, by regular U.S. mail.

/s/ RICHARD S. DONAHEY
Attorney for Appellant

THE SUPREME COURT OF THE STATE OF OHIO

October 14, 1976

No. 76-903

RONALD F. RIVIERE, D.D.S., INC.,
Appellant,

vs.

STATE OF OHIO ET AL.,
Appellees.

MOTION FOR AN ORDER DIRECTING THE COURT OF APPEALS FOR FRANKLIN COUNTY TO CERTIFY ITS RECORD

It is ordered by the Court that this motion is overruled.

COSTS:

Motion Fee, $20.00, paid by Richard S. Donahey.

I, Thomas L. Startzman, Clerk of the Supreme Court of Ohio, certify that the foregoing entry was correctly copied from the Journal of this Court.

Witness my hand and the seal of the Court
this ... day of ....., 19...

.....Clerk

.....Deputy

IN THE COURT OF APPEALS
OF FRANKLIN COUNTY, OHIO

No. 75AP-620

RONALD F. RIVIERE, D.D.S., INC.,
Plaintiff-Appellee,

vs.

STATE OF OHIO,
and
OHIO DEPARTMENT OF PUBLIC WELFARE,
and
THOMAS FERGUSON,
AUDITOR OF THE STATE OF OHIO,
Defendants-Appellants.

DECISION

Rendered on June 17, 1976

RICHARD S. DONAHEY and
JACK R. GRAF, JR.,
501 South High Street,
Columbus, Ohio,
For Plaintiff-Appellee.

WILLIAM J. BROWN, *Attorney General,*
TERRY L. TATARU and
ROBERT H. STROMBERG, *Assistants,*
State Office Tower, Room 1625,
30 East Broad Street,
Columbus, Ohio,
For Defendants-Appellants.

Appellee commenced an action against the State of Ohio, the Ohio Department of Public Welfare and Thomas E. Ferguson, Auditor of the State of Ohio, alleging that he had provided dental services to recipients of Medicaid and other medical assistance programs of the State of Ohio, administered through the Ohio Department of Public Welfare, and that defendants had failed to pay the amount due under the contract. Appellee sought an injunction against appellants, restraining them from withholding the payments due appellee and judgment in the amount of $70,000.00. The Ohio Department of Public Welfare served a counterclaim for $277,423.00.

The Auditor of the State then brought an original action of prohibition in this court against the trial court judge, asking that he be prohibited from hearing and determining the aforesaid case. This court, in case number 75AP-194, on May 28, 1975, issued a limited writ of prohibition, prohibiting the Court of Common Pleas from proceeding with the action complained of as against the State of Ohio, but permitting the Court of Common Pleas to proceed with the portion of the action pending therein, seeking injunctive relief against the Auditor of the State and the State Department of Welfare, as well as the counterclaim brought by the State Department of Welfare. The reasons for that decision are set forth fully in the opinion.

Upon remand, under the limited writ of prohibition, the issues as to the injunction were decided in favor of appellee and it is our understanding that payment has been made to appellee by appellants. Payment had been withheld solely on the basis of the counterclaim as a set-off.

The appellant, Ohio Department of Public Welfare,

had counterclaimed, demanding judgment against appellee in the amount of $277,423.00, which said department claimed they had overpaid appellee in the past for services rendered to welfare patients. The issues in the counterclaim were tried before a referee whose findings were adopted by the court. Judgment was entered in favor of appellee, from which a timely appeal has been taken.

Appellants set forth the following assignments of error:

> "(1) The trial court erred in holding that the referee properly interpreted the pertinent sections of the federal regulations and it erred in adopting the report of the referee as its own decision and in finding against defendant Ohio Department of Public Welfare on the counterclaim.
>
> "(2) The trial court erred in holding that judgment should issue in favor of plaintiff on his complaint.
>
> "(3) The trial court erred in holding that it had jurisdiction to entertain plaintiff's complaint."

The first assignment of error in this case decides the substantive matter at issue between the parties; that is, whether appellee was entitled to all the fees for dental services which were paid him by the Ohio Department of Public Welfare for the treatment of welfare patients. The amount which may be paid by the defendant department for each specific dental procedure or service rendered by a provider under the medical assistance program is controlled by 42 U.S.C. 1395 and the applicable federal regulations. Appellee had entered into a provider contract with the Ohio Department of Welfare to render dental services to welfare patients and, as a provider, was required to comply with federal and state law in his provider agreements.

In pertinent part, 45 C.F.R. section 250.30 provides:

> "(b) The upper limits for payments for care and services under a medical assistance plan are as follows:
>
> "* * *
>
> "(3)(a)(1) Payment to the individual practitioner is limited to the lowest of (i) His actual charge for service; (ii) The median of his charge for a given service derived from claims processed or from claims for services rendered during all of the calendar year preceding the start of the fiscal year in which the determination is made; or (iii) His reasonable charge recognized under part (B), title XVIII. * * *"

Reasonable charge is explained in 20 C.F.R. section 405.502 (A), which states in part that:

> "* * * The two criteria set out in the law which are considered in determining reasonable charges are:
>
> "(1) The customary charges for similar services generally made by the physician or other person furnishing such services; and
>
> "(2) The prevailing charges in the locality for similar services."

20 C.F.R. section 405.503 defines customary charges as:

> "(a) Customary charge defined. The term 'customary charges' will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in §405.506, be higher than the individual physician's or other person's customary charge."

The counterclaim was based on claimed higher pay-

ments than actually due for the period from 1968 through 1973, because it is contended that appellee charged the Ohio Department of Public Welfare a higher amount than he customarily charged those who were not welfare patients.

The facts clearly disclose that appellee used two fee schedules during all of the periods in question. One fee schedule was used when payment was made on an immediate basis. Immediate basis was defined as payment by cash, check or Bankamericard or Master Charge. A second fee schedule was used when there was a deferred fee. This fee schedule was used when there was a third-party payment, which was predominantly payment to be made by the Ohio Department of Public Welfare and only occasionally to be made by an insurance company.

During the years in question, appellee's clients were predominantly welfare patients for whom payments were made by the Ohio Department of Public Welfare. During 1968, from ninety to ninety-five per cent of his patients were welfare patients. In 1969, more than eighty per cent were welfare patients and from 1970 through 1973 more than fifty per cent of appellee's patients were welfare patients. Of the remaining patients, throughout these years, most were immediate-payment basis patients, as only occasionally was there a third-party insurance company involved.

An examination of the fee schedules shows that there was a very substantial difference between the amount of fees charged immediate-payment patients, as opposed to deferred-payment patients. For example, for certain x-rays, the charge for immediate pay was $5.00 as opposed to $30.00 for deferred pay; an increase of six times. An initial oral examination for immediate

pay was $8.00 and for deferred pay $20.00. For full upper dentures, the immediate pay cost was $100 as opposed to $235 for deferred pay. In examining the fee schedule, the charges are greatly increased for deferred pay, sometimes as much as six times what was charged on an immediate-pay basis.

Dr. Riviere testified that it was more expensive to do business on a deferred basis, but presented no statistical justification, instead stating that the cost for deferred-payment patients ranges from two and one-half times to six times higher, as in the indicated examples, "simply because I must have arbitrarily decided it to be that way." In another example, he was asked if there was any reason why the fee ought to be twice as high, and he stated "None, other than the fact that I elected to make it twice, sir." Later on, Dr. Riviere was asked why he had two fee schedules and chose to charge people that pay cash less. The answer was as follows:

> "I had indicated that there was one reason and it cost me money to do business with a deferred patient. I have other reasons, and the second reason is that I am interested in stimulating the immediate pay practice. I am trying to increase and stimulate that part of my business and I have done precisely that. As a result of this, that part of my practice is growing and growing quite large."

The legal issue, involved in determining whether appellee was restricted to charging the Ohio Department of Welfare the fees that he charged his immediate-pay patients, was whether in determining the customary charges of appellee his welfare patients could be included. If that is the case, appellee did not overcharge the Ohio Department of Public Welfare as it is conceded that even the higher deferred-patient

charges of appellee were lower than the prevailing charges in Columbus for similar services.

As previously stated, the regulation defines customary charges as the amount charged in the majority of cases for a similar medical procedure or service. Appellee argues, and the trial court so found, that welfare patients could be included in determining what is charged in the majority of cases. Since, at all times, a majority of appellee's patients were welfare patients, those charges would control if that interpretation is applied.

Appellants contend that welfare patients may not be included in determining customary charges and that, under federal regulation, appellee is restricted to the customary charges made to the majority of his other patients, i.e., the immediate-payment patients, and that he must refund the excess amount paid him based on his much higher deferred-fee schedule.

This court feels that the trial court erroneously interpreted the federal regulations in determining the calculation of appellee's customary charge. When the regulations were instituted, it was obviously intended to apply to dentists carrying on a private practice who wished to also service welfare patients. The reason for determining customary charges was to determine what to charge welfare patients. The proper method for determining the customary charge is to determine what was charged a majority of the time for each service performed for a dentist's private patients. In order to prevent a dentist who was doing charity work or work at lower than usual charges for welfare patients from being hurt by the regulation, the regulation, 20 C.F.R. section 405.503 (A), also provides that:

"Token charges for charity patients and substandard charges for welfare patients and other low income patients are to be excluded."

That provision should not be construed to mean that you can include welfare patients if the dentist charges more to them. If the regulation is interpreted to permit inclusion of welfare patients, when a provider reaches the point where he is doing a greater amount of welfare work than private work, as in appellee's case, he can charge any fee up to the allowable state maximum to the welfare patients, as it would be the fee charged the majority of the patients. By so doing, the provider's private practice could be subsidized and built up at the expense of the tax payer, as was candidly conceded to be done in this case.

Thus, you must look at the fees charged the majority of the provider's patients, excepting welfare patients or charity patients, to determine the customary charge. In appellee's case, the majority of those patients are the immediate-pay patients who are charged under the lower fee schedule.

Appellants' first assignment of error is sustained and the issues of the counterclaim are remanded to the trial court to determine the amount of damages applicable.

Appellants' second assignment of error is that the trial court erred in issuing injunctive relief against appellants to force the payment of state moneys that the auditor was holding as a set-off against the counterclaim, in the event appellants prevailed on the counterclaim.

We need not decide whether the trial court may hypothetically order injunctive relief prior to determination of a counterclaim in which a set-off might be applicable, as Civ. R. 54 prevented the trial court's

judgment on the first claim from becoming a final judgment at any time before the entry of judgment adjudicating all of the claims and the rights and liabilities of all of the parties, including the counterclaim. There was no express determination to the contrary, indicating no just reason for delay, as required by Civ. R. 54 (B), that would alter the usual finality of a partial judgment. Hence, appellants were not prejudiced by the trial court's determination. Moreover, the state of Ohio has issued all moneys to appellee which were due him on plaintiff's claim, which renders the issue moot. See *Mid-America Telephone v. Public Utilities Comm.* (1962), 173 Ohio St. 333. Assignment of error number two is overruled.

The third assignment of error is that the trial court erred in holding that it had jurisdiction to entertain plaintiff's complaint. As we previously held in the prohibition case in this very action, the Court of Common Pleas had jurisdiction over the issues herein, except as prohibited by the limited writ of prohibition. See *State, ex rel. Thomas Ferguson, v. The Honorable Fred J. Shoemaker*, unreported case number 75AP-194 (1975 Decisions, page 1165). Assignment of error number three is overruled.

Assignment of error number one is sustained and assignments of error number two and number three are overruled. The judgment of the trial court is reversed and the case is remanded to the trial court for further proceedings consistent with this decision.

HOLMES and REILLY, JJ., concur.

COURT OF COMMON PLEAS
OF FRANKLIN COUNTY, OHIO

Case No. 75CV-03-1292

RONALD F. RIVIERE, D.D.S., INC.,
Plaintiff,

vs.

STATE OF OHIO, ET AL.,
Defendants.

DECISION

Rendered this day of October, 1975.

SHOEMAKER, J.

Pursuant to Civil Rule 53, the Court reviewed the Report of Referee and Objections of Defendant thereto. The Court concludes that the Referee properly interpreted the pertinent sections of the Federal Regulations.

The Court, therefore, adopts the Report of the Referee as its own decision in this case. As the Decision of the Court is in favor of the Plaintiff against the Defendants, on the issue of Defendants' Counter-Claim, judgment for Plaintiffs is appropriate on Plaintiff's Complaint in Mandamus.

The Objections of Defendants are all OVERRULED.

Exceptions to Defendants.

Counsel for Plaintiff shall prepare an appropriate judgment entry as per court rule.

/s/ FRED J. SHOEMAKER, *Judge*

IN THE COURT OF COMMON PLEAS
OF FRANKLIN COUNTY, OHIO

Case No. 75CV-03-1292

RONALD F. RIVIERE, D.D.S., INC.,
Plaintiff,

vs.

STATE OF OHIO, ET AL.,
Defendants

JUDGMENT ENTRY

This cause came on for oral hearing on the 2nd day of September, 1975 on Defendants objections to the Report of the Referee and accompanying Motion, and the Court finding that the Referee properly interpreted the pertinent sections of the Federal Regulations and further finding Defendants objections to be without merit, it is therefore,

ORDERED ADJUDGED AND DECREED that Defendants motion for an order sustaining objections and modifying the recommendation of the Referee is hereby overruled and it is further,

ORDERED that judgment be entered in favor of Plaintiff and against Defendants on the issue of Defendants counter-claim and it is further,

ORDERED that judgment be granted in favor of Plaintiff on Plaintiffs complaint in mandamus and therefore it is further,

ORDERED that the bond heretofore posted by Plaintiff be released unto it.

Costs to Defendants.

/s/ FRED J. SHOEMAKER, *Judge*

APPROVED:
WILLIAM J. BROWN
Attorney General
JACK GRAF, JR.
Attorneys for Plaintiff

ROBERT H. STROMBERG
TERRY L. TATARU
ROY MARTIN
Assistant Attorneys General
Attorneys for Defendants

COURT OF COMMON PLEAS
OF FRANKLIN COUNTY, OHIO

RONALD F. RIVIERE, D.D.S., INC.,
Plaintiff,

vs.

STATE OF OHIO, ET AL.,
Defendants.

REPORT

Rendered this 30th day of July, 1975.

HAROLD PADDOCK, REFEREE:

Pursuant to Civil Rule 53 and the Reference in this case, the Referee hereby makes the following Report on the issue of Defendants' Counterclaim.

FINDINGS OF FACT

1. Plaintiff, Ronald F. Riviere, D.D.S., Inc., is a professional corporation organized under the Ohio Professional Corporations Act for the practice of dentistry in Columbus, Ohio. Dr. Ronald F. Riviere, D.D.S., is the President and sole shareholder of the professional corporation.

Defendants, State of Ohio, Ohio Department of Public Welfare and Thomas Ferguson, Auditor of the State of Ohio, are the entities and officials charged with the administration of the Medicaid program in Ohio. A dispute has arisen between the parties surrounding an Auditor's report and findings for recovery, alleging that Plaintiff was overpaid under Medicaid provider agreements.

2. In order to obtain Federal income tax advantages, Dr. Riviere has split his practice between his professional corporation and his individual capacity. His professional corporation has employed various dentists and auxiliary personnel over the years in order to provide dental services. The dental practice is charged for under a billing system which has immediate pay rates and deferred pay rates. Immediate pay rates cover those services for which the patient pays in cash or by bank credit card or by cashier's check or money order. Deferred payments are made on behalf of the patient by a third party, normally the State Welfare Department or, occasionally, an insurance company. All of the professional corporation's billing is on the deferred basis, and all of the doctor's individual billing is on the immediate pay basis. The fee schedules which the doctor has operated under for a number of years have lower rates for the immediate pay patients. Generally, the deferred pay basis is two to four times greater than the immediate pay rate for an identical dental service. The fee schedules (Defendant's Exhibits 2, 3 and 4) are incorporated into this Report as if fully rewritten herein. On the fee schedule effective February 8, 1975, Defendant's Exhibit 4, which was entered into after negotiations with the Defendants, the immediate pay fee is equal to or greater than the State proscribed maximum reimbursement fee. In general, on all three fee schedules, the deferred fee is greater than the State indicated fee.

Dr. Riviere and his corporation incurred higher costs in dealing on a deferred pay basis through increased paper work and increased diagnostic information necessary to obtain authorization from the third party prior to initiating various dental treatments. There is no specific breakdown as to the increase in

costs on each particular service. The increase in deferred fees over immediate pay fees is arbitrary in the sense that the doctor set those fees through his own decision, without itemized or broken down cost figures.

3. In the calendar year 1968, approximately 90-98% of the doctor's business was on deferred payment basis for the Welfare Department. In the calendar year of 1969, the percentage of deferred payments was greater than 80%. In 1970 through 1973, the percentage has exceeded 50%. The doctor operated throughout all these years under various Medicaid provider agreements. The Report of Examination of the State Auditor covers the period of time from January 1, 1968 to October 10, 1973. This report has been duly certified even though there was a typographical error on one copy of the Certification, causing some confusion as to whether the report covered the doctor in his individual or corporate capacity.

4. The fees charged under the deferred fee schedule have always been equal to or less than the prevailing fees in the Columbus area for identical dental services. The evidence is uncontradicted that Dr. Riviere and his professional corporation have always provided their patients with the highest quality dental care.

APPLICABLE FEDERAL CODE SECTIONS

For the benefit of the reader, the Referee includes in this Report the Sections of Title 20, Code of Federal Regulations, which the Referee feels are pertinent to this case:

§ 405.502 CRITERIA FOR DETERMINING REASONABLE CHARGES.

(a) Criteria. The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other persons furnishing

medical and other services but calls for individual determinations which take into account the facts as to existing practice with respect to charges of the particular physician or other person as well as others in the locality. The two criteria set out in the law which are considered in determining reasonable charges are:

(1) The customarw charges for similar services generally made by the physician or other person furnishing such services; and

(2) The prevailing charges in the locality for similar services. . . .

(c) Application of criteria. In applying these criteria, the carriers are to exercise judgment, based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charge are realistic and equitable. . . .

§ 405.503 DETERMINING CUSTOMARY CHARGES.

(a) Customary charge defined. The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in Section 405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. Payment for covered services would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within

the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be taken into account by the carrier in determining the amount which is considered to be the reasonable charge for the service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

(b) Variation of charges. If the individual physician or other person varies his charge for a specific medical procedure or service, so that no one amount is charged in the majority of cases, it will be necessary for the carrier to exercise judgment in the establishment of a "customary charge" for such physician or other person. In making this judgment, an important guide, to be utilized when a sufficient volume of data on the physician's or other person's charges is available, would be the median or midpoint of his charges, excluding token and substandard charges, as well as exceptional charges on the high side. A significant clustering of charges in the vicinity of the median amount might indicate that a point of such clustering should be taken as the physician's or other person's "customary" charge. . . .

(d) Revision of customary charge. A physician's or other person's customary charge is not necessarily a static amount. Where a physician or other person alters his charges, a revised pattern of charges for his services may develop. Where on the basis of adequate evidence, the carrier finds that the physician or other person furnishing services has changed his charge for a service to the public in general, the customary charge resulting from the revised charge for the service should be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries. . . .

CONCLUSIONS OF LAW

5. Dr. Riviere and his corporation are entitled to receive reimbursement under the Medicaid Provider Agreements and the applicable Federal regulations incorporated therein. Reimbursement of the "usual and customary fee" for each dental procedure is rendered for each patient eligible to receive Medicaid benefits. The usual and customary fee under the facts herein is the deferred payment fee in the doctor's schedule. As a statistical matter in the years covered by the Auditor's Report of Examination, a majority of the patients have always been Medicaid recipients or deferred payment patients.

6. Defendants' argument generally is that it is the command of the Federal Regulations that "usual and customary fee" be determined by a particular physician's billing to the general public, and then transferred to the doctor's Medicaid patients. The applicable Federal regulations, while complex, confusing and subject to some interpretation, could conceivably yield this interpretation. The Referee finds, taking the regulations in their entirety and considering how clearly the drafters *could have* articulated the theory of Defendants, but apparently did not, that the correct interpretation of the regulations is that a simple statistical majority of *all* the physician's patients, Medicaid and non-Medicaid, is to be used to determine the "usual and customary fee." Section 405.502 (a) with its reference to "existing practice with respect to charges of the particular physician" could be a recognition of the situation presented here where a doctor could choose to have largely or exclusively a Medicaid practice with little or no "general public" patients. Section 405.502 (c) with its language, "the charges made by physicians

to patients generally and by other persons to the public in general," indicates that the drafters could have made distinctions between "public in general" and "Medicaid recipients" in other Code sections but apparently did not. Section 405.503 (a), the primary Code section to be construed here, simply states, "majority of cases," rather than majority of non-recipient or non-Medicaid cases. The language in the next sentence as to token charges or substandard charges cannot be turned 180 degrees to mean that all charges higher than desired by the carrier should be excluded from the computation of usual and customary. Later in Section (a) the sentences which prohibit the inclusion of the recipients' economic status in the decision making process could be read to indicate that the immediate pay patients with their ability to pay by cash or BancAmericard should be excluded from the computation of charges for Medicaid patients. Section 405.503 (b) indicates that a statistical method such as drawing a bell curve would be appropriate for determining usual and customary fees. Obviously, the bell curve of the fee schedules in this case would indicate that the median or midpoint would fall directly on the fixed fee in the bulk of the cases, namely, the deferred fee cases. Section (d) indicates that the drafters could have used the phrases, "charge for a service to the public in general," and "supplementary insurance beneficiaries," to make clear any distinction that they felt was necessary in the inclusion or exclusion of Medicaid recipients from the statistical testing of what is the "majority of cases."

7. There is nothing in the regulations which indicates that a physician cannot arbitrarily set up a fee schedule. Any price for any goods or service is to some

extent arbitrary whenever it is set up in advance and never bargained or haggled over. There is nothing in the regulations which indicates that a doctor cannot set up a practice based largely or entirely upon services to Medicaid recipients. If such a practice were set up (as such practice was in this case) the drafters of the regulations intended that the same criterion of usual and customary fees apply. In any event, there is no evidence that Dr. Riviere or his corporation have been gouging the Defendants by charging more than the prevailing fees in the Columbus area for identical dental treatment.

8. As the "usual and customary fees" of Dr. Riviere and his professional corporation are those fees on his schedule considered to be deferred fees, there is no justification for a finding of recovery on grounds that the fees should have been lower or something different. Therefore, the Report of Examination of the State Auditor is based on an improper interpretation of the applicable regulations and does not create liability upon the Plaintiff to return funds to the Defendants.

9. While the Report of Examination creates a prima facie case on behalf of the Defendants on their Counterclaim, this Court is not bound by any of the legal conclusions therein; *Hoare v. City of Cleveland*, 126 Oh. St. 625 (1933) and the evidence presented has sufficiently overcome the prima facie case.

RECOMMENDATIONS

Therefore, the Referee recommends that judgment on the Defendants' Counterclaim be for the Plaintiffs and against the Defendants. The parties shall have fourteen (14) days from the date of this Report within

which to file their Objections, pursuant to Civil Rule 53 and local Rule 59.

/s/ HAROLD PADDOCK, *Referee*

Appearances:
RICHARD DONAHEY
BYRON VICKERY
JACK GRAF
For Plaintiffs

ROBERT H. STROMBERG
TERRY L. TATARU
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For Defendants

IN THE COURT OF COMMON PLEAS
OF FRANKLIN COUNTY, OHIO
CIVIL DIVISION

Case No. 75CV-03-1292

RONALD F. RIVIERE, D.D.S., INC.,
Plaintiff,

vs.

STATE OF OHIO, ET AL.,
Defendants.

POST-TRIAL ARGUMENT AND BRIEF

This case began with the filing of a complaint seeking injunctive relief by the plaintiff, Dr. Ronald F. Riviere, D.D.S., Inc., to restrain the defendants from illegally withholding plaintiff's funds. The defendants filed a counter-claim against plaintiff alleging that, between the period of January 1, 1968, and October 10, 1973, the defendants overpaid the plaintiff in the amount of $277,423.00. At a pre-trial hearing, it was agreed by the parties that this case should proceed on the liability portion of the counter-claim brought by the defendants, and that both parties would stand by the previously determined evidence and briefs already filed with the Court which were used in granting the temporary restraining order.

The basic issue in this case is the question of whether Dr. Ronald F. Riviere, D.D.S., Inc., charged the State of Ohio *more* than his usual and customary fee. The State of Ohio relied upon Section 117.11 of the Ohio Revised Code as its basis for merely introducing a copy of the Auditor's Report as *prima facie* evidence.

Section 117.11 of the Ohio Revised Code provides in its pertinent part as follows:

> "(A) A *certified* copy of any portion of such report is *prima facie* evidence of the truth of the allegations of the petition." (Emphasis added.)

However, a *certified* copy of the report did not come in as evidence. This item was marked as defendant's Exhibit 1 in the trial, and was admitted into evidence over objection *after the certification was withdrawn* by the attorney for the State. Page 18 of the transcript of the trial states, in its pertinent parts, as follows:

> "MR. STROMBERG: At this time I would like to offer into evidence the part of Defendants' Exhibit 1, marked The Report of Examination, Volume 1, and Volume 2, *and I will withdraw the certification.*" (Emphasis added.)

Furthermore, as was brought out during the trial by objection, much of defendant's Exhibit 1 is comprised of "comments" and other hearsay matters which were unsubstantiated and unverified by the person or persons preparing the report. In *Hoare v. City of Cleveland, Heiser Bros. Company, et al., v. same*, 126 Ohio St. 625, 186 N.E. 710 (1933), the Supreme Court of Ohio held as follows:

> "* * * The principal legal question was the admissibility in evidence of the report of the State Examiner of the Bureau of Inspection of public offices in Ohio under Section 286-1, General Code. . .
> This report was offered in evidence and received by the trial court in its entirety. Many parts of this report embody hearsay statements, arguments, deductions, inferences, conclusions of law, etc., which should not have been offered in evidence. The trial court, when the report was presented, and objected to by the defendant, should have rejected all such inadmissible statements. Section 286-1 does not permit the admission in evidence of such conclusions, hearsay and evidential statements. * * *"

Quite clearly, then, even if this Honorable Court feels that the report as such complied with the certification requirements of Section 117.11 of the Ohio Revised Code, its value as *prima facie* evidence is substantially reduced by virtue of the *Hoare* case. The plaintiff in this case should prevail on this and this alone, since no other evidence was offered by the State of Ohio in support of its counter-claim.

Assuming for the moment that this Honorable Court does not agree with the above arguments, and that the plaintiff had the burden of "bursting the bubble" with regard to the introduction of some evidence to overcome the *prima facie* evidence, certainly the testimony of Ronald F. Riviere not only burst the bubble, but overwhelmingly established that the allegations made by the State of Ohio are simply untrue, if not unproven.

The evidence clearly showed that Dr. Ronald F. Riviere operates in two business capacities, one as an individual practitioner, and the second as Dr. Ronald F. Riviere, D.D.S., Inc. Dr. Riviere explained that the reasons for the two business entities came about as a result of the size of his business and at the insistence of both the Internal Revenue Service and the State of Ohio Department of Welfare. Even if the decision was arbitrary, there is absolutely no provision in the law anywhere in the world which prevents him from operating his practice in this manner.

This case turns upon the definition of "usual and customary fee". This has been agreed upon by all. Furthermore, the plaintiff in this case was only required to charge the Department of Public Welfare

his usual and customary fee for that period of time covered by the provider contracts with the State of Ohio. The State's own evidence clearly showed that, with respect to his West Broad Street office, a provider contract has only been in force since October 26, 1972. This was Exhibit 7. Therefore, Dr. Riviere was not limited to his "usual and customary fee" prior to October 26, 1972, for fees generated in his West Broad Street office.

The State's own evidence further showed that the first time a provider agreement was entered into with regard to the Livingston Avenue office was May 11, 1971. This is State's Exhibit 9. Prior to May 11, 1971, the plaintiff was not bound by his "usual and customary fee". Even the provider agreement signed on October 26, 1972, State's Exhibit 6, does not state that the plaintiff agrees to comply with the rules and regulations of the Department of Public Welfare. The provider contract provides the extent of the agreement within its four corners, and this cannot be elaborated upon by the Welfare Department, the Auditor of the State of Ohio or the Courts. Of course, the plaintiff did charge only his usual and customary fee at all times while dealing with the Department of Welfare, even though he was not required to do so. However, for purposes of this suit, the time periods during which the "usual and customary fee" definitions become important are only during the later time periods.

It is necessary now to look at the multitude of federal regulations which help us determine the definition of "usual and customary fees". The Code of Federal Regulations, Volume 20, Section 405.503, "Determining Customary Charges", states as follows:

> "(a) Customary charges defined. The term "customary charges" will refer to the uniform amount which the individual physician or person charges in the *majority* of cases for a specific medical procedure or service. . . The customary charge for different physicians or other persons may, of course, vary." (Emphasis added.)

The *Medicare and Medicaid Guide*, Volume 1, Section 3185, paragraph 3.05, at pages 1362 and 1363 provides as follows:

> "The term 'customary charges' refers to the amount which the individual physician usually and *most frequently* charges his patients for a specific service in similar medical circumstances . . .
>
> Where the physician charges a uniform amount to the *majority* of his patients for a *specific* service, this amount would be his customary charge . . ." (Emphasis added.)

There are many other references to the usual and customary fee in the Federal Regulations, but they all center around the words "majority" and "specific services". Even if we take the plaintiff's position at its worst, that is, lumping both his welfare and non-welfare patients (immediate and deferred payment categories), the testimony is abundantly clear that well over a majority, that is, more than fifty per cent, of all of the patients of both Dr. Riviere individually and Dr. Ronald F. Riviere, D.D.S., Inc., were welfare cases during the period of January 1, 1968, through October 10, 1973. This is the *only* evidence regarding which portion of the total patients were welfare and which portion of them were non-welfare, *even including* Exhibit 1, the Auditor's Report. In addition, there is absolutely no finding in the Auditor's report regarding proportions between welfare and non-welfare as

they relate to "specific services". The law requires that the Auditor must make a finding with regard to each specific service rendered by the plaintiff as to what his usual and customary fee is for that service. For example, under the category of "repair broken denture", there is not the barest allegation in the Auditor's Report that more than a majority of the patients having this service performed during the audit period were non-welfare (immediate pay) patients.

The unrebutted evidence of the samplings taken by the Auditor's office in compiling their report was that two hundred to three hundred patient files out of some forty thousand patient file were examined. Furthermore, the evidence is that these files were mostly, if not all, "non-welfare" (immediate pay) patients.

There is absolutely no way that this limited search of the records could be construed to be a fair sampling. Furthermore, the unrebutted and sole evidence concerning the plaintiff's official records and its customary fee was Dr. Riviere's testimony when he stated that there were no such records which could ever establish that his usual and customary fee was his non-welfare (immediate) fee.

From the outset, the Auditor makes the unsubstantiated assumption in its report that the plaintiff's usual and customary fee is its *immediate* fee, and not its *deferred* fee. These allegations appear time and time again in the report without any substantiation whatsoever other than that it conveniently fits their theories. Furthermore, the sole evidence in the trial was that the plaintiff's highest fees were equal to or lower than the prevailing fees in the community.

For any one of and for all of the foregoing reasons,

the counter-claim of defendants should fail, and judgment should be entered for the plaintiff.

Respectfully submitted,

/s/ RICHARD S. DONAHEY
Attorney for Plaintiff
501 S. High Street
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224-8166

CERTIFICATE OF SERVICE

A true and exact copy of the foregoing Post-Trial Argument and Brief was delivered on this 16th day of June, 1975, to Robert Stromberg, Assistant Attorney General and Attorney for Defendants, State Office Tower, Suite 1625, 30 E. Broad Street, Columbus, Ohio 43215.

/s/ RICHARD S. DONAHEY
Attorney for Plaintiff

§1395cc. Agreements with providers of services

(a)(1) Any provider of services (except a fund designated for purposes of section 1395f(g) and section 1395n(c) of this title) shall be qualified to participate under this subchapter and shall be eligible for payments under this subchapter if it files with the Secretary an agreement—

(A) not to charge, except as provided in paragraph (2), any individual or any other person for items or services for which such individual is entitled to have payment made under this subchapter (or for which he would be so entitled if such provider of services had complied with the procedural and other requirements under or pursuant to this subchapter or for which such provider is paid pursuant to the provisions of section 1395f(e) of this title), and

(B) not to charge any individual or any other person for items or services for which such individual is not entitled to have payment made under this subchapter because payment for expenses incurred for such items or services may not be made by reason of the provisions of paragraph (1) or (9), but only if (i) such individual was without fault in incurring such expenses and (ii) the Secretary's determination that such payment may not be made for such items and services was made after the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this subchapter, and

(C) to make adequate provision for return (or other disposition, in accordance with regulations) of any moneys incorrectly collected from such individual or other person.

An agreement under this paragraph with a skilled nursing facility shall be for a term of not exceeding 12 months, except that the Secretary may extend such term for a period not exceeding 2 months, where the health and safety of patients will not be jeopardized thereby, if he finds that such extension is necessary to prevent irreparable harm to such facility or hardship to the individuals being furnished items or services by such facility or if he finds it impracticable within such 12-month period to determine whether such facility is complying with the provisions of this subchapter and regulations thereunder.

(2)(A) A provider of services may charge such individual or other person (i) the amount of any deduction or coinsurance amount imposed pursuant to section 1395e(a)(1) or (a)(3), section 1395l(b), or section 1395x(y)(3) of this title with respect to such items and services (not in excess of the amount customarily charged for such items and services by such provider). and (ii) an amount equal to 20 per centum of the reasonable charges for such items and services (not in excess of 20 per centum of the amount customarily charged for such items and services by such provider) for which payment is made under part B. In the case of items and services described in section 1395l(c) of this title, clause (ii) of the preceding sentence shall be applied by substituting for 20 percent the proportion which is appropriate under such section.

(B)(i) Where a provider of services has furnished, at the request of such individual, items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider of services may also charge such individual or other person for such

more expensive items or services to the extent that the amount customarily charged by it for the items or services furnished at such request exceeds the amount customarily charged by it for the items or services with respect to which payment may be made under this subchapter.

(ii) Where a provider of services customarily furnishes an individual items or services which are more expensive than the items or services determined to be necessary in the efficient delivery of needed health services under this subchapter and which have not been requested by such individual, such provider may (except with respect to emergency services) also charge such individual or other person for such more expensive items or services to the extent that the costs of (or, if less, the customary charges for) such more expensive items or services experienced by such provider in the second fiscal period immediately preceding the fiscal period in which such charges are imposed exceed the cost of such items or services determined to be necessary in the efficient delivery of needed health services, but only if—

(I) the Secretary has provided notice to the public of any charges being imposed on individuals entitled to benefits under this subchapter on account of costs in excess of the costs determined to be necessary in the efficient delivery of needed health services under this subchapter by particular providers of services in the area in which such items or services are furnished, and

(II) the provider of services has identified such charges to such individual or other person, in such manner as the Secretary may prescribe, as charges to meet costs in excess of the cost determined to be necessary in the efficient delivery of needed health services under this subchapter.

(C) A provider of services may in accordance with its customary practice also appropriately charge any such individual for any whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished him with respect to which a deductible is imposed under section 1395e(a)(2) of this title, except that (i) any excess of such charge over the cost to such provider for the blood (or equivalent quantities of packed red blood cells, as so defined) shall be deducted from any payment to such provider under this subchapter, (ii) no such charge may be imposed for the cost of administration of such blood (or equivalent quantities of packed red blood cells, as so defined) and (iii) such charge may not be made to the extent such blood (or equivalent quantities of packed red blood cells, as so defined) has been replaced on behalf of such individual or arrangements have been made for its replacement on his behalf. For purposes of this subparagraph, whole blood (or equivalent quantities of packed red blood cells, as so defined) furnished an individual shall be deemed replaced when the provider of services is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is imposed under section 1395e(a)(2) of this title.

(D) Where a provider of services customarily furnishes items or services which are in excess of or more expensive than the items or services with respect to which payment may be made under this subchapter, such provider, notwithstanding the preceding provisions of this paragraph, may not, under the authority of subparagraph (B)(ii) of this paragraph, charge any individual or other person any amount for such

items or services in excess of the amount of the payment which may otherwise be made for such items or services under this subchapter if the admitting physician has a direct or indirect financial interest in such provider.

(b) An agreement with the Secretary under this section may be terminated (and in the case of a skilled nursing facility, prior to the end of the term specified in subsection (a)(1) of this section)—

(1) by the provider of services at such time and upon such notice to the Secretary and the public as may be provided in regulations, except that notice of more than 6 months shall not be required, or

(2) by the Secretary at such time and upon such reasonable notice to the provider of services and the public as may be specified in regulations, but only after the Secretary has determined (A) that such provider of services is not complying substantially with the provisions of such agreement, or with the provisions of this subchapter and regulations thereunder, or (B) that such provider of services no longer substantially meets the applicable provisions of section 1395x of this title, or (C) that such provider of services has failed to provide such information as the Secretary finds necessary to determine whether payments are or were due under this subchapter and the amounts thereof, or has refused to permit such examination of its fiscal and other records by or on behalf of the Secretary as may be neecssary to verify such information, or (D) that such provider has made, or caused to be made, any false statement or representation of a material fact for use in an application for payment under this subchapter or for use in determining the right to a payment under this subchapter, or (E) that such provider has submitted, or caused to be submitted, requests for

payment under this subchapter of amounts for rendering services substantially in excess of the costs incurred by such provider for rendering such services, or (F) that such provider has furnished services or supplies which are determined by the Secretary, with the concurrence of the members of the appropriate program review team appointed pursuant to section 1395y(d)(4) of this title who are physicians or other professional personnel in the health care field, to be substantially in excess of the needs of individuals or to be harmful to individuals or to be of a grossly inferior quality.

Any termination shall be applicable—

(3) in the case of inpatient hospital services (including tuberculosis hospital services and inpatient psychiatric hospital services) or post-hospital extended care services, with respect to services furnished after the effective date of such termination, except that payment may be made for up to thirty days with respect to inpatient institutional services furnished to any eligible individual who was admitted to such institution prior to the effective date of such termination.

(4)(A) with respect to home health services furnished to an individual under a plan therefor established on or after the effective date of such termination, or (B) if a plan is established before such effective date, with respect to such services furnished to such individual after the calendar year in which such termination is effective, and

(5) with respect to any other items and services furnished on or after the effective date of such termination.

(c)(1) Where an agreement filed under this subchapter by a provider of services has been terminated by the Secretary, such provider may not file another agreement under this subchapter unless the Secretary finds that the reason for the termination has been re-

moved and that there is reasonable assurance that it will not recur.

(2) In the case of a skilled nursing facility participating in the programs established by this subchapter and subchapter XIX of this chapter, the Secretary may enter into an agreement under this section only if such facility has been approved pursuant to section 1396i of this title, and the term of any such agreement shall be in accordance with the period of approval of eligibility specified by the Secretary pursuant to such section.

(d) If the Secretary finds that there is a substantial failure to make timely review in accordance with section 1395x(k) of this title of long-stay cases in a hospital or skilled nursing facility, he may, in lieu of terminating his agreement with such hospital or facility, decide that, with respect to any individual admitted to such hospital or facility after a subsequent date specified by him, no payment shall be made under this subchapter for inpatient hospital services (including inpatient tuberculosis hospital services and inpatient psychiatric hospital services) after the 20th day of a continuous period of such services or for post-hospital extended care services after such day of a continuous period of such care as is prescribed in or pursuant to regulations, as the case may be. Such decision may be made effective only after such notice to the hospital, or (in the case of a skilled nursing facility) to the facility and the hospital or hospitals with which it has a transfer agreement, and to the public, as may be prescribed by regulations, and its effectiveness shall terminate when the Secretary finds that the reason therefor has been removed and that there is reasonable assurance that it will not recur. The Secretary

shall not make any such decision except after reasonable notice and opportunity for hearing to the institution or agency affected thereby.

(e) For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1395x(p)(4)(A) of this title, or if, in the case of a public health agency, such agency meets the requirements of section 1395x(p)(4)(B) of this title, but only with respect to the furnishing of outpatient physical therapy services (as therein defined). Aug. 14, 1935, c. 531. Title XVIII, §1866, as added July 30, 1965, Pub.L. 89-97, Title I, §102(a), 79 Stat. 327, and amended Jan. 2, 1968, Pub.L. 90-248, Title I, §§129(c)(12), 133(c), 135(b), 81 Stat. 849, 851, 852; Oct. 30, 1972, Pub.L. 92-603, Title II, §§223(e), (g), 227(d)(2), 229(b), 249A(b)-(d), 278(a)(17), (b)(18), 281(c), 86 Stat. 1394, 1406, 1409, 1427, 1453-1455.

§405.502 Criteria for determining reasonable charges.

(a) *Criteria.* The law does not contemplate the establishment of a general fee schedule applicable to all physicians or other persons furnishing medical and other services but calls for individual determinations which take into account the facts as to existing practice with respect to charges of the particular physician or other person as well as others in the locality. The two criteria set out in the law which are considered in determining reasonable charges are:

(1) The customary charges for similar services generally made by the physician or other person furnishing such services; and

(2) The prevailing charges in the locality for similar services.

(b) *Comparable services limitation.* The law also specifies that the reasonable charge cannot be higher than the charge applicable for a comparable service under comparable circumstances to the carriers' own policyholders and subscribers.

(c) *Application of criteria.* In applying these criteria, the carriers are to exercise judgment based on factual data on the charges made by physicians to patients generally and by other persons to the public in general and on special factors that may exist in individual cases so that determinations of reasonable charge are realistic and equitable.

(d) *Responsibility of Administration and carriers.* Determinations by carriers of reasonable charge are not reviewed on a case-by-case basis by the Social Security Administration, although the general procedures and performance of functions by carriers are evaluated. In making determinations, carriers apply the provisions of the law under broad principles issued by the Social Security Administration. These principles are intended to assure overall consistency among carriers in their determinations of reasonable charge. The principles in §§405.503-405.507 establish the criteria for making such determinations in accordance with the statutory provisions.

(e) *Criteria for determination of reasonable charges under the charge renal disease program.* With respect to reimbursement for services in connection with renal dialysis and kidney transplantation, the normal medical market in which customary and prevailing charges can be determined will not be available; most such services will be reimbursed by the health insurance program. With respect to such service therefore, reasonable charges may be defined in terms related to charges or costs prior to July 1, 1973, the costs and profits that are reasonable when the treatments are provided in an effective and economical manner, and/or charges made for other services, taking into account comparable physicians' time and skill requirements. Definitions may be developed which describe the elements of service included within the scope of a dialysis treatment and limits may be established on charges and services above which reimbursement shall be made only upon appropriate justification.

[32 FR 12599, Aug. 31, 1967, as amended at 38 FR 17212, June 29, 1973]

20 CODE OF FEDERAL REGULATIONS §405.503

§405.503 Determining customary charges.

(a) *Customary charge defined.* The term "customary charges" will refer to the uniform amount which the individual physician or other person charges in the majority of cases for a specific medical procedure or service. In determining such uniform amount, token charges for charity patients and substandard charges for welfare and other low income patients are to be excluded. The reasonable charge cannot, except as provided in §405.506, be higher than the individual physician's or other person's customary charge. The customary charge for different physicians or other persons may, of course, vary. Payment for covered services would be based on the actual charge for the service when, in a given instance, that charge is less than the amount which the carrier would otherwise have found to be within the limits of acceptable charges for the particular service. Moreover, the income of the individual beneficiary is not to be taken into account by the carrier in determining the amount which is considered to be a reasonable charge for a service rendered to him. There is no provision in the law for a carrier to evaluate the reasonableness of charges in light of an individual beneficiary's economic status.

(b) *Variation of charges.* If the individual physician or other person varies his charges for a specific medical procedure or service, so that no one amount is charged in the majority of cases, it will be necessary for the carrier to exercise judgment in the establishment of a "customary charge" for such physician or other person. In making this judgment, an important guide, to be utilized when a sufficient volume of data on the physician's or other person's charges is available, would be the median or midpoint of his charges,

excluding token and substandard charges as well as exceptional charges on the high side. A significant clustering of charges in the vicinity of the median amount might indicate that a point of such clustering should be taken as the physician's or other person's "customary" charge. Use of relative value scales will help in arriving at a decision in such instances.

(c) *Use of relative value scales.* If, for a particular medical procedure or service, the carrier is unable to determine the customary charge on the basis of reliable statistical data (for example, because the carrier does not yet have sufficient data or because the performance of the particular medical procedure or service by the physician or other person is infrequent), the carrier may use appropriate relative value scales to determine the customary charge for such procedure or service in relation to customary charges of the same physician or person for other medical procedures and services.

(d) *Revision of customary charge.* A physician's or other person's customary charge is not necessarily a static amount. Where a physician or other person alters his charges, a revised pattern of charges for his services may develop. Where on the basis of adequate evidence, the carrier finds that the physician or other person furnishing services has changed his charge for a service to the public in general, the customary charge resulting from the revised charge for the service should be recognized as the customary charge in making determinations of reasonable charges for such service when rendered thereafter to supplementary insurance beneficiaries. If the new customary charge is not above the top of the range of prevailing charges (see §405.504 (a)), it should be deemed to be reasonable by the carrier, subject to the provisions of §405.508.

(3) Data concerning payments for medical assistance under title XIX on behalf of recipients subject to sampling under the medical assistance program; and

(4) A comprehensive plan for analysis of and corrective action on the findings of each sampling period provided for in paragraph (c) of this section, no later than 135 days after the end of each sampling period.

(c) There shall be a sampling period from July 1, 1975 to September 30, 1975, and sampling periods of 6 months each thereafter commencing October 1, 1975, to collect the data referred to in paragraph (b)(2) and (3) of this section. Such data shall be submitted to SRS no later than 120 days after the end of each sampling period.

[40 FR 27221, June 27, 1975]

§250.30 Reasonable charges.

(a) *State plan requirements.* A State plan for medical assistance under title XIX of the Social Security Act must:

(1) Include a description of the policy and the methods to be used in establishing payment rates for each type of care or service listed in section 1905(a) of the Act that is included in the State's medical assistance program.

(2) Provide for payment of the reasonable cost of inpatient hospital services as determined in accordance with methods and standards, consistent with the provisions of section 1122 of the Social Security Act for participating States, which shall be developed by the State and approved in advance of implementation by the Regional Commissioner, Social and Rehabilitation Service. Under this requirement:

(i) Plans for payment of reasonable cost will be approved which adopt the title XVIII standards and

principles described in 20 CFR 405.402-405.455 (excluding the inpatient routine nursing salary cost differential). However, with respect to cost reporting periods beginning after December 31, 1973, payments to hospitals for inpatient services shall be based on the lesser of the reasonable cost of services or the customary charges to the general public for such services, or, in the case of public hospitals rendering services free of or at a nominal charge, on the basis of fair compensation for such services, in accordance with the provisions of title XVIII regulations.

(ii) For other plans, criteria for approval will include:

(*a*) Incentives for efficiency and economy;

(*b*) Reimbursement on a reasonable cost basis;

(*c*) Reimbursement not to exceed that which would be produced through the application of the title XVIII standards and principles of reimbursement, as modified under paragraph (a)(2)(i) of this section;

(*d*) Assurance of adequate participation of hospitals and availability of hospitals services of high quality to title XIX recipients;

(*e*) Adequate documentation for evaluation of experience under the State's approved reimbursement plan.

State title XIX agencies are encouraged to involve representative provider organizations in the development of such plans and to work closely with title V grantees, the Social Security Administration, and other Governmental purchasers of hospital care in an attempt to achieve coordination in reimbursement methods within States.

(iii) Plans for payment of reasonable cost will not be approved under which payment for inpatient hospital services exceeds the amount which would be determined as reasonable cost using the title XVIII standards and principles described in 20 CFR 405.402-

405.455 (excluding the inpatient routine nursing salary cost differential) as modified under paragraph (a)(2)(i) of this section.

(3) Provide that payments for care or service are not in excess of the upper limits described in paragraph (b) of this section.

(4) Provide that the single State agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus costs of materials.

(5) Provide assurance that the State agency has access to data identifying the maximum charges allowed and that such data will be made available to the Secretary of Health, Education, and Welfare upon request.

(6) Provide that fee structures will be established which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

(7) Provide that participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure, except that, with respect to payment for care furnished in skilled nursing facilities and services in intermediate care facilities, existing supplementation programs are permitted where the State has determined and advised the Secretary of Health, Education, and Welfare that its payments for such care or services furnished under the plan are less than the reasonable cost of such care or services permitted under Federal regulations, and the State has, prior to January 1, 1971, in the case of skilled nursing facilities, and the effective date of these regulations, in the case of intermediate care facilities, provided the Secretary

with a plan for phasing out such supplementation within a reasonable period after the applicable date.

(8) Provide that any increase in a payment structure that applies to individual practitioner services shall be documented in State manuals or other official files by:

(i) An estimate of the percentile of the range of customary charges to which the revised payment structure equates and a description of the methods used in arriving at the estimate.

(ii) An estimate of the composite average percentage increase of the revised fee structure over its predecessor. Criteria for meeting Federal requirements pertaining to such payment structures are set forth in paragraph (b)(3)(i)(A) of this section.

(b) *Upper limits.* The upper limits for payments for care and services under a medical assistance plan are as follows: The State agency may pay less than the upper limits. These upper limits do not apply to payments made under the State plan for deductibles and coinsurance imposed under title XVIII of the Social Security Act. Such payments may be made up to the reasonable charge under title XVIII. A State which pays for reserved beds in long term care facilities pursuant to paragraph (d) of this section may set payment rates for such reserved beds in an amount less than the rate paid for care in the facility if it is determined by the State that a differential exists between the cost of reserving a bed and the cost of providing care.

(1) *Inpatient hospital services.* The upper limits for payment shall not exceed the payment which would be determined as reasonable cost using the title XVIII standards and principles described in 20 CFR 405.402-405.455 (excluding the inpatient routine nursing salary cost differential). However, with respect to cost reporting periods beginning after December 31, 1973,

payments to hospitals for inpatient services shall be based on the lesser of the reasonable cost of services or the customary charges to the general public for such services, or, in the case of public hospitals rendering services free of or at a nominal charge, on the basis of fair compensation for such services, in accordance with the provisions of title XVIII regulations.

(2) *Drugs.* The upper limit for payment for prescribed drugs — whether legend items (for which a prescription is required under Federal law) or nonlegend items—shall be based on the lower of the cost of the drug (as determined in accordance with paragraphs (b) (2) (ii) or (iii) of this section) plus a dispensing fee established by the State, or the provider's usual and customary charge to the general public.

(i) In establishing the dispensing fee, States should take into account the results of surveys of costs of pharmacy operation. States shall periodically conduct such surveys of pharmacy operational data including such components as overhead, professional services and profits.

(*a*) The dispensing fee may vary according to the size and location of the pharmacy and according to whether the dispensing is done by a physician or by an outpatient drug department of an institution and according to whether the drug is a legend or a nonlegend item.

(*b*) The dispensing fee may also vary for prescribed drugs furnished to title XIX recipients in an institutional setting by a pharmacy employing a unit dose system. In such instances the dispensing fee may be either: (*1*) An amount added to the cost of each unit dose furnished by the pharmacy or (*2*) a daily or monthly capitation rate per resident for whom prescribed drugs are being furnished. In either case, the dispensing fee is added to the ingredient cost of the prescribed drug which is actually consumed.

(ii) For each multiple source drug designated by the Pharmaceutical Reimbursement Board and published in the FEDERAL REGISTER, cost will be limited to the lowest of (*a*) the maximum allowable cost established by the Board for such drug, and published in the FEDERAL REGISTER, or (*b*) the estimated acquisition cost (as defined in paragraph (b) (2) (iii), or (*c*) the provider's usual and customary charge to the general public; except that such limitation shall not apply in any case where a physician certifies in his own handwriting that in his medical judgment a specific brand is medically necessary for a particular patient. The form and procedure for the certification shall be prescribed by the State. An example of an acceptable certification would be the notation "brand necessary." A procedure for checking a box on a form will not constitute an acceptable certification. At the discretion of the State, the certification may be retained by the provider rather than submitted with the claim form with the understanding that it will be available for inspection by the State and by the Department of Health, Education, and Welfare.

(iii) For all other prescribed drugs, cost shall not exceed an upper limit established by the State. This shall be the State's closest estimate of the price generally and currently paid by providers. Such estimates shall be based on the package size of drugs most frequently purchased by providers. To aid States in making cost estimates, the Department will make available information on a current basis on acquisition costs of the most frequently purchased package size of drugs. These data will cover the majority of the most frequently prescribed drugs.

(iv) The upper limits governing reimbursement by State agencies to providers of prescribed drugs spefied in this section shall also apply in cases where prescribed drugs are furnished as part of skilled nursing

facility or intermediate care facility services or under prepaid capitation arrangements. Contracts between the State agency and the underwriter, carrier, foundation, health maintenance organization or other insurers containing the terms of such prepaid capitation arrangements shall include a provision imposing the same upper limits for reimbursement or prescribed drugs as are imposed by paragraph (b)(2) of this section on the State agency.

(3) *Other services*—(i) *Noninstitutional services*—(A) *Payments to individual practitioners.* (This applies to services of doctors of medicine, dentistry, osteopathy, and podiatry. At the option of the State, other individual practitioner services may be included.) A payment structure will meet Federal requirements if (as documented in State manuals or other official files):

(*1*) Payment to the indiivdual practitioner is limited to the lowest of

(*i*) His actual charge for service;

(*ii*) The median of his charge for a given service derived from claims processed or from claims for services rendered during all of the calendar year preceding the start of the fiscal year in which the determination is made: or

(*iii*) His reasonable charge recognized under part B, title XVIII.

(*2*) In no case may payment exceed the highest of

(*i*) Beginning July 1, 1971, the 75th percentile of the range of weighted customary charges in the same localities established under title XVIII during the calendar year preceding the fiscal year in which the determination is made;

(*ii*) The prevailing charge recognized under part B, title XVIII, for similar services in the same locality on December 31, 1970 and found acceptable by the Secretary; or

(*iii*) The prevailing reasonable charge recognized under part B, title XVIII.

(B) *Other noninstitutional services.* The upper limits for payment shall be customary charges which are reasonable. The prevailing charges in the locality for comparable services under comparable circumstances shall set the upper limits for payments. In reviewing prevailing charges for reasonableness, the State agency should consider the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the carriers under part B, title XVIII of the Act and beneficiaries under such title, and the combined payments received from other third-party insuring organizations and their regular policy holders and subscribers, using whichever of these criteria or other criteria are appropriate to the specific provider service.

(ii) *Skilled nursing home services, outpatient hospital services, and clinic services.* Customary charges which are reasonable. Schedules of payments established by the State agency shall not exceed the combined payments received by providers (for furnishing comparable services under comparable circumstances) from the intermediaries or carriers under title XVIII and beneficiaries under title XVIII of the Social Security Act. Schedules will be acceptable if within the upper limits either on a facility by facility basis or on the basis of average payments according to a reasonable classification of facilities based on levels of care. (In case of providers which are not participating under title XVIII, a financial audit of the facilities to apply the title XVIII—A reimbursement principles is not required but the State shall establish schedules of charges which are consistent with the intent that upper limits do not exceed amounts paid under title XVIII—A for similar services.)

(iii) *Intermediate care facility services.* (*a*) Cus-

tomary charges which are reasonable. Schedules of payments established by the State agency shall not exceed an upper limit determined in accordance with the principles of reimbursement for provider costs under Part A of title XVIII of the Act. (A financial audit of the facilities to apply the title XVIII-A reimbursement principles is not required but the State shall establish schedules of payments which are consistent with the intent that upper limits do not exceed amount which would be paid using title XVIII-A principles and methods of cost reimbursement for similar service.)

(*b*) (*1*) Federal financial participation is not available for expenditures under the State plan for payments to intermediate care facilities, except for institutions for the mentally retarded and persons with related conditions which are exempted from this requirement, for any calendar quarter which are in excess of that amount which reflects a reasonable differential on a Statewide basis between average per diem amounts paid under the State plan for intermediate care facility services and the Statewide average per diem amounts paid under the State plan for skilled nursing facility services. Such reasonable differential shall reflect a lower rate of reimbursement for intermediate care.

(*2*) The differential shall be computed by determining the dollar amount of difference between the average amount paid per inpatient day under the State plan for skilled nursing facility services and the average amount paid per inpatient day under the State plan for intermediate care facility services, regardless of the basis for reinbursement, whether a flat rate, a negotiated rate, or a cost-related rate.

(*3*) In no case shall the statewide differential computed in accordance with paragraph (b) (3) (iii) (b) (2) be less than 10 percent of the statewide skilled

nursing facility rate except as provided in paragraph (b) (3) (iii) (b) (5).

(*4*) States must report each quarter on the Quarterly Statement of Expenditures (Form SRS-OA-41) separately for skilled nursing facility services and intermediate care facility services, the total amount paid during the quarter for services, the number of inpatient days of services paid for during the quarter, and the average amount paid per inpatient day for services during the quarter. The single State agency shall have on file adequate records to substantiate the quarterly statement of expenditures.

(*5*) The Administrator may approve a State's request for a cost differential of less than 10 per cent if he determines that such differential is reasonable. A State requesting approval of a cost differential of less than 10 percent must submit cost-related data to demonstrate such lesser differential is reasonable. The Administrator in approving a cost differential of less than 10 percent will indicate the period for which such differential is approved.

(4) *Prepaid capitation arrangements.* The upper limit for payment for services provided on a prepaid capitation basis shall be established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The cost for providing a given scope of services to a given number of individuals under a capitation arrangement shall not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

(c) *Waiver of experiments.* Any limitations on reimbursement imposed by the provisions of this section may be waived by the Secretary with respect to experiments conducted under the provisions of section 402, Public Law 90-426, Incentives for Economy Experimentation.

(d) *Federal financial participation.*—(1) *General* Federal financial participation is available for payments within the upper limits described in paragraph (b) of this section, in accordance with the provisions of the State plan.

(2) *Payments during recipient's absence from long term care facility.* (i) Federal financial participation is available in vendor payments which are necessary to reserve a bed in a long term care facility (skilled nursing facility, intermediate care facility, tuberculosis or mental hospital, or chronic care part of a general hospital facility) for a recipient during a temporary absence in a hospital for an acute condition or for therapeutically indicated home visits (defined to include visits with relatives and friends, and leaves to participate in State-approved therapeutic or rehabilitative programs).

(*a*) The following conditions will be met in any instance in which a bed is reserved;

(*1*) The State plan provides for such payments:

(*2*) Payment is made only for those days during which there is a likelihood that the reserved bed would otherwise be required for occupancy by some other patient. Determinations as to whether there is a likelihood that a bed is otherwise required for occupancy shall be based on analysis of current facility occupancy patterns in the locality and other pertinent data; and

(*b*) The following conditions will be met when a bed is reserved in a long term care facility because of the recipient's hospitalization for an acute condition:

(*1*) The single State agency has approved the recipient's hospitalization for an acute condition prior to each period of hospitalization during which a bed in another facility has been reserved. In case of an emergency admission such authorization will be obtained as soon as possible after admission.

(*2*) The single State agency has approved the bed

reservation for the recipient prior to each period of hospitalization. In case of an emergency admission such authorization will be obtained as soon as possible after admission.

(*3*) The patient intends to return to the same facility after hospitalization.

(*4*) The hospital provides a discharge plan for the recipient.

(*c*) In the case of therapeutic home visits, the patient's plan of care provides for such visits.

(ii) Federal financial participation in the cost of reserving a bed for purposes of paragraph (d) (2) of this section is available for (*a*) periods of hospitalization for acute conditions not to exceed 15 days per any single hospital stay and for (*b*) therapeutically indicated home visits not to exceed 3 days per visit nor six such visits per patient during any 12-month period, limited to two visits in any calendar quarter. The limitations do not apply in the case of patients in institutions for the mentally retarded or persons with related conditions (see § 249.13(a) (1) (xi) (E) of this chapter). Where the limitations for therapeutic visits interfere with a State approved therapeutic or rehabilitative program, the State agency may submit a request for special limits to the Regional Commissioner. In addition, the State shall obtain, and submit to the Regional Commission as requested, data on long-term care recipients who make home visits.

[34 F.R. 1244, Jan. 25, 1969, as amended at 35 F.R. 10013, June 18, 1970; 36 F.R. 12621, July 2, 1971; 36 F.R. 21591, Nov. 11, 1971; 39 FR 2235, Jan. 17, 1974; 39 21135, June 19, 1974; 39 FR 28268, Aug. 6, 1974; 39 FR 31639, Aug. 30, 1974; 39 FR 43632, Dec. 17, 1974; 40 FR 14598, Apr. 1, 1975; 40 FR 15388, Apr. 7, 1975; 40 FR 34519, Aug. 15, 1975]

NOTE: For interim policy published in uncodified form, see 34 F.R. 11098, July 1, 1969.

EFFECTIVE DATE NOTE: § 250.30 (b) (2) is effective Apr. 26, 1976.